

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-004365

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317

Primary Registration District No. 500

Registrar's No. 283

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUD

AMENDED

VS 300  
Rev. 4/59

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DATE AMENDED

INSTEAD OF

SHOULD READ

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Florissant</b>		Length of stay in 1b <b>3 1/2 years</b>	c. CITY OR TOWN <b>Florissant</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>1115 Florland Dr.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1115 Florland Dr.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>LEON FERMAN BAILEY</b>		4. DATE OF DEATH Month Day Year <b>Jan. 23, 1963</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2-16-1915</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>A.O. Smith Auto Frames Mfr.</b>	9. AGE (last birthday) <b>47</b> IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HR
11a. BIRTHPLACE (City and state or country) <b>Van Buren, Ark.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Sidney Bailey</b>		13b. MOTHER'S MAIDEN NAME <b>Nellie Hogan</b>	
14. NAME OF HUSBAND OR WIFE <b>Wanda</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <b>Yes WWII</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>1115 Florland Dr</b> <b>Mrs. Wanda Bailey, Florissant, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Pancreas 6 mos</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <b>9-20-63</b> to <b>1-23-63</b> and last saw her alive on <b>1-21-63</b> Death occurred at <b>8 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <b>John W. Ferguson MD</b>	
22b. ADDRESS <b>Ferguson MO</b>		22c. DATE SIGNED <b>1-24-63</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>1-26-63</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Festus Methodist</b>		23d. LOCATION (City, town, or county) <b>Festus, Mo.</b>	
24. FUNERAL DIRECTOR <b>The Florissant Mortuary, Florissant, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>1-25-63</b>	
26. REGISTRAR'S SIGNATURE <b>John W. Ferguson MD</b>			

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR

TYPEWRITER RIBBON

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Gene A. Hutchins

Licensed Embalmer No. 4966

P. O. Address Florissant, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.